STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012131	A. BUILDING: _____ B. WING _____	C 09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF NORTHWESTERN INDIANA	9509 GEORGIA ST CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00182218 Unsubstantiated: lack of sufficient evidence. Date: 9/23/15 Facility Number: 012131 Vibra Hospital of Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: JL 09/30/15	S 000		